

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER Southwood Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2222 Margaret Ave Terre Haute, IN 47802	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48226</p> <p>Based on observation, record review, and interview, the facility failed to ensure medications were administered and documented according to physician orders for administration of insulin for 4 of 4 residents reviewed for medication administration (Residents, D, F, B, and E).</p> <p>Findings include:</p> <p>1. On 4/9/25 at 10:00 a.m., during an initial observation and interview of Residents D and E. The residents indicated they had received their insulin. They were not sure of times of administration and indicated it was administered at breakfast.</p> <p>On 4/9/25 at 1:40 p.m., observed Licensed Practical Nurse (LPN) 7, at the medication administration cart. The LPN indicated she was not usually late administering insulin.</p> <p>On 4/9/25 at 1:05 p.m. during interview with Resident D. She indicated she received her insulin around 12:30 p.m., She indicated she did not eat breakfast that a.m. but she did receive insulin. She did not know what time it was administered. She indicated she usually got her insulin before she ate but it did vary.</p> <p>On 4/9/25 at 2:10 p.m., during interview with Resident E, the resident indicated she thought her insulin was administered before meals, but she did not know the times it was administered.</p> <p>On 4/10/25 at 7:00 a.m., observed Registered Nurse (RN) 9, administering medications to residents. The employee indicated she had not administered insulin to residents and would administer insulins with their breakfast.</p> <p>On 4/10/25 at 10:40 a.m., the medical record of Resident D was reviewed. The resident was admitted to the facility on [DATE]. Admitting diagnosis included, but were not limited to, type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high), with diabetic neuropathy (a type of nerve damage that can occur if you have diabetes).</p> <p>A care plan, dated 10/7/20, indicated the resident had diabetes mellitus and was at risk for complications. Interventions included but were not limited to, diabetes medication as ordered by doctor.</p> <p>A Minimum Data Set (MDS) assessment, dated 3/31/25, indicated the resident was cognitively intact and received insulin injections during the look back period.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A physician order, dated 3/3/25 and 3/19/25, indicated to administer insulin, Aspart Flex Pen 100 unit/ml solution pen-injector, inject 10 unit subcutaneously (under the skin) before meals for diabetes mellitus. Administration times were 7:30 a.m., 11:30 a.m., and 4:30 p.m.</p> <p>A physician order, dated 3/3/25, indicated to administer insulin glargine solostar subcutaneous solution pen-injector 100 unit/ml (Glargine), inject 30 unit subcutaneously one time a day for diabetes. Administration time was indicated as AM.</p> <p>A physician order, dated 3/19/25, indicated to administer Lantus SoloStar 100 unit/ml Solution pen-injector, inject 30 unit subcutaneously at bedtime for Diabetes Mellitus. Administration time was indicated as HS (hour of sleep). The medical record lacked documentation of administration Lantus insulin on 3/26/25.</p> <p>A physician order, dated 3/21/25 at 10:15 p.m., indicated to administer insulin lispro subcutaneous solution pen injector 100 unit/ml (Insulin Lispro), inject 15 unit subcutaneously STAT (immediately) for hyperglycemia (high blood sugar). The medical record lacked documentation of administration of insulin.</p> <p>A physician order, dated 3/22/25, indicated to administer insulin lispro, injection solution 100 unit/ml (Insulin Lispro) inject subcutaneously before meals and at bedtime for diabetes mellitus as per sliding scale. (Sliding scale insulin is units of insulin that is administered according to the range of the residents blood sugar reading): For blood sugar of 100 - 150 = 0 units; blood sugar of 151 - 200 = 2 units; blood sugar of 201 - 250 = 4 units; blood sugar of 251 - 300 = 6 units; blood sugar of 301 - 350 = 8 units; blood sugar of 351 - 400 = 10 units; and blood sugar of 401 - 999 = 12 units. Administration times were 7:00 a.m., 11:00 a.m., 4:00 p.m., and 9:00 p.m.</p> <p>From 3/3/25 to 3/11/25, Glargine insulin was scheduled to be administered at 7:00 a.m., the record indicated the insulin was administered at the following times:</p> <p>3/3/25 - 9:32 a.m.</p> <p>3/4/25 - 11:48 a.m.</p> <p>3/6/25 - 9:40 a.m.</p> <p>3/8/25 - 9:25 a.m.</p> <p>3/9/25 - 9:38 a.m.</p> <p>3/10/25 - 9:28 a.m.</p> <p>3/11/25 - 11:01 a.m.</p> <p>From 3/1/25 to 3/31/25, Aspart insulin was to be administered at 7:30 a.m. the MAR indicated the insulin was administered at the following times.</p> <p>3/4/25 - 11:47 a.m.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3/6/25 -10:25 p.m.</p> <p>3/10/25 - 11:29 p.m.</p> <p>From 3/21/25 to 3/31/25, Aspart insulin was to be administered at 5:30 p.m., the MAR indicated the insulin was administered at the following times.</p> <p>3/21/25 - 10:37 p.m.</p> <p>3/23/25 - 10:21 p.m.</p> <p>3/24/25 - 9:56 p.m.</p> <p>3/30/25 - 8:00 p.m.</p> <p>3/31/25 - 8:21 p.m.</p> <p>On 3/22/25, 3/23/25, 3/24/25, 3/25/25, 3/26/25, 3/27/25, 3/28/25, 3/29/25, 3/30/25, 3/32/25 and 4/1/25. Lispro insulin sliding scale, was not documented as administered.</p> <p>From 4/1/25 to 4/10/25, Aspart insulin was to be administered at 7:30 a.m., the MAR indicated the insulin was administered at the following times.</p> <p>4/3/25 - 10:47 a.m.</p> <p>4/4/25 - 3:23 p.m.</p> <p>4/7/25 - 9:24 a.m.</p> <p>4/9/25 - 9:56 a.m.</p> <p>From 4/1/25 to 4/10/25, Aspart insulin was to be administered at 11:30 a.m., the MAR indicated the insulin was administered at the following times.</p> <p>4/4/25 - 3:24 p.m.</p> <p>4/9/25 - 1:44 p.m.</p> <p>From 4/1/25 to 4/10/25, Aspart insulin was to be administered at 4:00 p.m., the MAR indicated the insulin was administered at the following times.</p> <p>4/7/25 - 7:25 p.m.</p> <p>4/8/25 - 6:49 p.m.</p> <p>From 4/1/25 to 4/10/25, Aspart insulin was to be administered at 5:30 p.m., the MAR indicated the insulin was administered at the following times.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Resident F's record was reviewed on 4/10/25 at 11:00 a.m. The profile indicated the resident's diagnosis included but were not limited to, type 2 diabetes mellitus with hyperglycemia (occurs when a person with diabetes has persistently high blood sugar levels [hyperglycemia] due to insulin resistance and/or insufficient insulin production).</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 1/24/25, indicated the resident had moderate cognitive deficit and was on insulin injections.</p> <p>A care plan, initiated on 2/2/24 and revised on 2/24/24, indicated the resident had diabetes and was at risk of complications. Interventions included but were not limited to, administer medication per provider's orders and observe for side effects and effectiveness.</p> <p>A physician order, dated 4/17/24, indicated to administer Lispro (insulin medication) subcutaneous (under the skin) solution pen injector 100 unit/ml (milliliter), inject 10 units subcutaneously before meals for type 2 diabetes mellitus at 7:30 a.m., 11:30 a.m., and 4:30 p.m.</p> <p>Review of March 2025 MAR indicated the Lispro insulin medication was documented as administered at the following times:</p> <ul style="list-style-type: none"> a. On 3/1/25 the 7:30 am. dose was documented as administered at 6:37 p.m. b. On 3/1/25 the 11:30 a.m. dose was documented as administered at 3:11 p.m. c. On 3/1/25 the 4:30 p.m. dose was documented as administered at 9:48 p.m. d. On 3/2/25 the 7:30 a.m. dose was documented as administered at 2:07 p.m. e. On 3/2/25 the 11:30 a.m. dose was documented as administered at 2:07 p.m. f. On 3/3/25 the 4:30 p.m. dose was documented as administered at 8:36 p.m. g. On 3/6/25 the 7:30 a.m. dose was documented as administered at 9:23 a.m. h. On 3/6/25 the 4:30 p.m. dose was documented as administered at 9:30 p.m. i. On 3/7/25 the 7:30 a.m. dose was documented as administered at 10:24 a.m. j. On 3/7/25 the 11:30 a.m. dose was documented as administered at 1:18 p.m. k. On 3/8/25 the 11:30 a.m. dose was documented as administered at 1:08 p.m. l. On 3/9/25 the 7:30 a.m. dose was documented as administered at 11:39 a.m. m. On 3/10/25 the 7:30 a.m. dose was documented as administered at 11:29 a.m. n. On 3/10/25 the 4:30 p.m. dose was documented as administered at 11:15 p.m. o. On 3/11/25 the 7:30 a.m. dose was documented as administered at 9:42 a.m. <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>p. On 3/11/25 the 4:30 p.m. dose was documented as administered at 5:58 p.m.</p> <p>q. On 3/12/25 the 7:30 a.m. dose was documented as administered at 9:01 a.m.</p> <p>r. On 3/13/25 the 11:30 a.m. dose was documented as administered at 1:39 p.m.</p> <p>s. On 3/14/25 the 11:30 a.m. dose was documented as administered at 1:16 p.m.</p> <p>t. On 3/14/25 the 4:30 p.m. dose was documented as administered at 7:47 p.m.</p> <p>u. On 3/25/25 the 11:30 a.m. dose was documented as administered on 3/17/25 at 5:20 p.m.</p> <p>v. On 3/15/25 the 4:30 p.m. dose was documented as administered at 9:10 p.m.</p> <p>w. On 3/16/25 the 7:30 a.m. dose was documented as administered at 9:14 a.m.</p> <p>x. On 3/16/25 the 4:30 p.m. dose was documented as administered at 7:20 p.m.</p> <p>y. On 3/17/25 the 4:30 p.m. dose was documented as administered at 7:08 p.m.</p> <p>z. On 3/18/25 the 4:30 p.m. dose was documented as administered at 9:33 a.m.</p> <p>aa. On 3/19/25 the 7:30 a.m. dose was documented as administered at 9:22 a.m.</p> <p>bb. On 3/21/25 the 7:30 a.m. dose was documented as administered at 9:15 a.m.</p> <p>cc. On 3/21/25 the 4:30 p.m. dose was documented as administered at 10:53 p.m.</p> <p>dd. On 3/23/25 the 11:30 a.m. dose was documented as administered at 1:23 p.m.</p> <p>ee. On 3/24/25 the 7:30 a.m. dose was documented as administered at 10:25 a.m.</p> <p>ff. On 3/24/25 the 11:30 a.m. dose was documented as administered at 12:50 p.m.</p> <p>gg. On 3/24/25 the 4:30 p.m. dose was documented as administered at 9:50 p.m.</p> <p>hh. On 3/25/25 the 11:30 a.m. dose was documented as administered at 4:41 p.m.</p> <p>ii. On 3/25/25 the 4:30 p.m. dose was documented as administered at 6:12 p.m.</p> <p>jj. On 3/26/25 the 7:30 a.m. dose was documented as administered at 3:42 p.m.</p> <p>kk. On 3/26/25 the 11:30 a.m. dose was documented as administered at 3:43 p.m.</p> <p>ll. On 3/26/25 the 4:30 p.m. dose was documented as administered on 3/27/25 at 9:49 a.m.</p> <p>mm. On 3/27/25 the 7:30 a.m. dose was documented as administered at 9:17 a.m.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>nn. On 3/28/25 the 11:30 a.m. dose was documented as administered at 1:04 p.m.</p> <p>oo. On 3/29/25 the 4:30 p.m. dose was documented as administered at 6:16 p.m.</p> <p>pp. On 3/30/25 the 7:30 a.m. dose was documented as administered at 9:26 a.m.</p> <p>qq. On 3/31/25 the 4:30 p.m. dose was documented as administered at 8:13 p.m.</p> <p>A physician order, dated 4/16/24, indicated to administer Glargine (insulin medication) solution pen injector 100unit/ml, inject 30 units subcutaneously in the evening for diabetes at 9:00 p.m.</p> <p>Review of March 2025 MAR indicated the Glargine insulin medication was documented as administered at the following times:</p> <p>a. On 3/2/25 the 9:00 p.m. dose was documented as administered on 3/12/25 at 2:05 p.m.</p> <p>b. On 3/10/25 the 9:00 p.m. dose was documented as administered at 11:15 p.m.</p> <p>c. On 3/16/25 the 9:00 p.m. dose was documented as administered on 3/17/25 at 7:21 p.m.</p> <p>d. On 3/17/25 the 9:00 p.m. dose was documented as administered on 3/18/25 at 10:16 a.m.</p> <p>e. On 3/21/25 the 9:00 p.m. dose was documented as administered at 10:53 p.m.</p> <p>Review of April 2025 MAR indicated the Lispro insulin medication was documented as administered at the following times:</p> <p>a. On 4/1/25 the 4:30 p.m. dose was documented as administered at 9:47 p.m.</p> <p>b. On 4/3/25 the 7:30 a.m. dose was documented as administered at 10:58 a.m.</p> <p>c. On 4/6/25 the 11:30 a.m. dose was documented as administered at 1:20 p.m.</p> <p>d. On 4/9/25 the 7:30 a.m. dose was documented as administered at 10:10 a.m.</p> <p>e. On 4/9/25 the 11:30 a.m. dose was documented as administered at 12:57 p.m.</p> <p>During an interview, on 4/10/25 at 11:41 a.m., Resident F indicated she sometimes received her insulin before meals and sometimes it was much later. She indicated the insulin administration times were all over the place.</p> <p>34525</p> <p>3. During an interview on 4/9/25 at 11:20 a.m., Resident B indicated it was always a 50/50 shot whether he received his insulin (a hormone produced by the pancreas that helps regulate blood sugar levels) injections on time. On this date he had just received his 8:00 a.m. injection just prior to the beginning of the interview.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident B's record was reviewed on 4/9/25 at 10:51 a.m. The profile indicated the resident's diagnoses included, but were not limited to, type 2 diabetes mellitus with hyperglycemia (a chronic condition that happens when a person has persistently high blood sugar levels).</p> <p>An admission Minimum Data Set (MDS) assessment, dated 3/12/25, indicated the resident had no cognitive deficit, no documented behaviors for rejection of care, and received insulin injections.</p> <p>The resident's care plans lacked documentation of the resident having care plans related to his diagnosis of diabetes or that he received insulin injections.</p> <p>A physician's order, dated 3/6/25, indicated to administer insulin Lispro (a rapid-acting insulin used to lower blood sugar levels in people with diabetes) injection solution 100 units/milliliter (ml), subcutaneously (below the skin) before meals and at bedtime, (at 8:00 a.m., 11:00 a.m., 4:00 p.m., and 9:00 p.m.) for diabetes, per the following sliding scale: if blood sugar of 151 - 199 = 2 units; blood sugar of 200 - 249 = 4 units; blood sugar of 250 - 299 = 6 units; blood sugar of 300 - 349 = 8 units; blood sugar of 350 - 399 = 10 units; blood sugar of 400 - 449 = 12 units; blood sugar of 450 - 499 = 14 units; blood sugar of 500 - 549 = 16 units; blood sugar of 550 - 599 = 18 units. If blood sugar was greater than 599 call the physician.</p> <p>Review of the March 2025 Medication Administration Audit Report, the resident's Lispro administrations had been administered late on the following dates:</p> <p>a. The 8:00 a.m., dose was documented as administered late on, 3/7/25, 3/8/25, 3/9/25, 3/11/25, 3/14/25, 3/16/25, 3/18/25, 3/21/25, 3/22/25, 3/24/25, 3/26/25, 3/29/25, 3/30/25, and 3/31/25.</p> <p>b. The 11:00 a.m., dose was documented as administered late on, 3/7/25, 3/8/25, 3/9/25, 3/10/25, 3/12/25, 3/13/25, 3/14/25, 3/15/25, 3/17/25, 3/18/25, 3/19/25, 3/20/25, 3/21/25, 3/22/25, 3/23/25, 3/24/25, 3/25/25, 3/26/25, 3/28/25, 3/30/25, and 3/31/25.</p> <p>c. The 4:00 p.m., dose was documented as administered late on, 3/6/25, 3/7/25, 3/8/25, 3/10/25, 3/11/25, 3/12/25, 3/13/25, 3/15/25, 3/16/25, 3/17/25, 3/18/25, 3/19/25, 3/21/25, 3/22/25, 3/23/25, 3/24/25, 3/25/25, 3/28/25, 3/29/25, 3/30/25, and 3/31/25.</p> <p>d. The 9:00 p.m., dose was documented as administered late on, 3/6/25, 3/10/25, 3/16/25, 3/17/25, 3/20/25, 3/21/25, 3/23/25, and 3/25/25.</p> <p>Review of the April 2025 Medication Administration Audit Report, the resident's Lispro administrations had been administered late on the following dates:</p> <p>a. The 8:00 a.m., dose was documented as administered late on, 4/1/25, 4/4/25, 4/7/25, and 4/9/25.</p> <p>b. The 11:00 a.m., dose was documented as administered late on, 4/2/25, 4/4/25, 4/7/25, and 4/9/25.</p> <p>c. The 4:00 p.m., dose was documented as administered late on, 4/1/25, 4/2/25, 4/6/25, 4/7/25, 4/8/25, and 4/9/25.</p> <p>d. The 9:00 p.m., dose was documented as administered late on, 4/2/25, 4/4/25, 4/5/25, and 4/6/25.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER Southwood Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2222 Margaret Ave Terre Haute, IN 47802	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A physician's order, dated 3/6/25, indicated to administer 35 units of insulin Glargine (a synthetic version of human insulin) subcutaneous solution 100 units/ml, two times daily for diabetes, at 7:00 a.m., and 9:00 p.m.</p> <p>Review of the March 2025 Medication Administration Audit Report, the resident's Glargine administrations had been administered late on the following dates:</p> <p>a. The 9:00 p.m., dose was documented as administered late on, 3/10/25, 3/16/25, 3/17/25, and 3/20/25.</p> <p>Review of the April 2025 Medication Administration Audit Report, the resident's Glagine administrations had been administered late on the following dates:</p> <p>a. The 7:00 a.m., dose was documented as administered late on, 4/18/25, 4/26/25, and 4/29/25.</p> <p>b. The 9:00 p.m., dose was documented as administered late on, 4/10/25, 4/16/25, 4/17/25, and 4/20/25.</p> <p>4. Resident E's record was reviewed on 4/10/25 at 8:53 a.m. The profile indicated the resident diagnoses included, but were not limited to, type 2 diabetes with diabetic chronic kidney disease (a chronic condition that happens when a persons high blood sugar levels damage the kidneys so that they cannot filter blood effectively).</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 3/28/25, indicated the resident had no cognitive deficit, no documented behaviors of refusals of medications, and the resident received insulin injections.</p> <p>A care plan, revised on 3/20/22, indicated the resident had a potential for complications related to her diagnoses of diabetes. Interventions included, but were not limited to, administer diabetes medication as ordered by the doctor.</p> <p>A physician's order, dated 11/4/24, indicated to administer 50 units of Lantus solution (a a long-acting man-made-insulin used to control high blood sugar in adults) 100 units/ml, subcutaneously two times a day for diabetes, at 8:00 a.m., and 8:00 p.m.</p> <p>Review of the March 2025 Medication Administration Audit Report, the resident's Lantus administrations had been administered late on the following dates:</p> <p>a. The 8:00 a.m., dose was documented as administered late on, 3/2/25, 3/3/25, 3/4/25, 3/6/25, 3/13/25, 3/14/25, 3/16/25, 3/18/25, 3/21/25. 3/22/25, 3/24/25, 3/26/25, 3/29/25, 3/30/25, and 3/31/25.</p> <p>b. The 8:00 p.m., dose was documented as administered late on, 3/1/25, 3/4/25, 3/5/25, 3/6/25, 3/8/25, 3/10/25, 3/12/25, 3/13/25, 3/16/25, 3/19/25, 3/20/25, 3/21/25, 3/23/25, 3/24/25, and 3/25/25.</p> <p>Review of the April 2025 Medication Administration Audit Report, the resident's Lantus administrations had been administered late on the following dates:</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. The 8:00 a.m., dose was documented as administered late on, 4/3/25, 4/4/25, 4/7/25, 4/9/25, and 4/10/25.</p> <p>b. The 8:00 p.m., dose was documented as administered late on, 4/1/25 and 4/5/25.</p> <p>A physician's order, dated 11/21/24, indicated to administer insulin Lispro (a rapid-acting insulin used to lower blood sugar levels in people with diabetes) solution Pen-injector (an injection device used to deliver preloaded insulin into the subcutaneous [under the skin] tissue) 100 units/milliliter (ml). Inject 22 unit subcutaneously before meals for diabetes, at 7:30 a.m., 11:30 a.m., and 4:30 p.m.</p> <p>Review of the March 2025 Medication Administration Audit Report, the resident's Lispro administrations had been administered late on the following dates:</p> <p>a. The 7:30 a.m., dose was documented as administered late on, 3/1/25, 3/2/25, 3/3/25, 3/4/25, 3/5/25, 3/6/25, 3/9/25, 3/13/25, 3/14/25, 3/16/25, 3/17/25, 3/18/25, 3/19/25, 3/20/25, 3/21/25, 3/22/25, 3/24/25, 3/26/25, 3/27/25, 3/28/25, 3/29/25, 3/30/25, and 3/31/25.</p> <p>b. The 11:30 a.m., dose was documented as administered late on, 3/2/25, 3/6/25, 3/8/25, 3/9/25, 3/10/25, 3/12/25, 3/13/25, 3/14/25, 3/15/25, 3/19/25, 3/21/25, 3/22/25, 3/23/25, 3/24/25, 3/26/25, 3/30/25, and 3/31/25.</p> <p>c. The 4:30 p.m., dose was documented as administered late on, 3/1/25, 3/3/25, 3/4/25, 3/6/25, 3/8/25, 3/10/25, 3/11/25, 3/12/25, 3/13/25, 3/14/25, 3/15/25, 3/16/25, 3/18/25, 3/21/25, 3/22/25, 3/23/25, 3/24/25, 3/29/25, 3/30/25, and 3/31/25.</p> <p>Review of the April 2025 Medication Administration Audit Report, the resident's Lispro administrations had been administered late on the following dates:</p> <p>a. The 7:30 a.m., dose was documented as administered late on, 4/2/25, 4/3/25, 4/4/25, 4/7/25, 4/8/25, 4/9/25, and 4/10/25.</p> <p>b. The 11:30 a.m., dose was documented as administered late on, 4/3/25, 4/4/25, 4/7/25, and 4/9/25.</p> <p>c. The 4:30 p.m., dose was documented as administered late on, 4/1/25, 4/8/25, and 4/9/25.</p> <p>During an interview, on 4/9/25 at 1:40 p.m., Licensed Practical Nurse (LPN) 7 indicated she was late administering insulin to residents because she was administering insulin to residents on three different halls and was completely overwhelmed.</p> <p>During interview, on 4/10/25 at 7:10 a.m., Registered Nurse (RN) 8 indicated she would document medications at the time she administered them. If the medication was scheduled for morning or bedtime she would administer the medication within two hours. If a medication was scheduled for a specific time she would give it according to the scheduled administration time.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During interview, on 4/10/25 at 7:30 a.m., LPN 7 indicated she administered medications according to the administration times. If she was late documenting the administration of a medication, she would change the administration time to the actual time she administered the medication.</p> <p>On 4/10/25 at 9:00 a.m., the Regional Nurse Consultant provide a document, dated 2013, titled, Medication Administration, and indicated it was the policy currently being used by the facility. The policy indicated , . Procedure: I. General Procedures: 1 a. Administer medications only as prescribed by the provider .f. Observe the five rights in giving medication: .ii. the right time .ff. Medications will be administered within the time frame of one hour before up to one hour after time ordered .IV. Documentation: a. Documentation of medication will be current for medication administration. b. Documentation of medication will follow accepted standards of nursing practice</p> <p>This citation relates to Complaint IN00456945.</p> <p>3.1-48(c)(2)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>38847</p> <p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review, the facility failed to ensure enhanced barrier precautions were followed during a dressing change for 1 of 3 residents reviewed for pressure ulcers (Resident G).</p> <p>Findings include:</p> <p>During a continuous observation, on 4/10/25 from 9:56 a.m. to 10:16 a.m., the following was observed. Licensed Practical Nurse (LPN) 7 performed hand hygiene, donned gloves and a gown, and completed the dressing change to Resident G's sacrum (bone at the base of the spine). Near the end of the sacrum dressing change, Certified Nurse Aide (CNA) 11 entered the room to assist LPN 7. CNA 11 did not perform hand hygiene after entering the room. CNA 11 donned gloves but did not put on a gown. CNA 11 held up Resident G's left heel so LPN 7 could complete the dressing change to that area. CNA 11 removed the dressing from Resident G's left heel and continued to hold up the resident's leg. CNA 11 did not perform hand hygiene or change gloves after she removed the resident's dressing.</p> <p>On 4/10/25 at 10:16 a.m., the continuous observation was completed. At the same time, LPN 7 indicated CNA 11 should have performed hand hygiene before she put on her gloves. CNA 11 should have worn a gown and should not have removed the dressing from Resident G's heel. Resident G required enhanced barrier precautions (strategic use of gown and gloves during high-contact resident care activities) during his wound care.</p> <p>Resident G's record was reviewed on 4/9/25 at 2:33 p.m. Diagnoses on the resident's profile included, but were not limited to, stage four (deep wound that extends into all underlying tissues such as muscles, tendons, and bones) pressure ulcer (local injury to the skin and underlying tissues caused by prolonged pressure) of the sacral region.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 3/10/25, indicated the resident was cognitively intact and required pressure ulcer care.</p> <p>A physician's order, dated 1/7/25, indicated the resident required enhanced barrier precautions related to wounds.</p> <p>A physician's order, dated 3/24/25, indicated to cleanse the resident's left heel wound with wound cleanser, pat dry with gauze, apply skin prep (skin barrier) around the wound, apply collagen (promotes wound healing) to the wound bed, and cover with bordered gauze daily.</p> <p>A physician's order, dated 4/7/25, indicated to cleanse the resident's sacrum wound with wound cleanser, pat dry with gauze apply skin prep around the wound, apply Hydrofera Blue (absorbent foam wound dressing) to wound bed, cover with an abdominal (ABD) pad (dressing that manages moderately draining wounds), and secure with tape daily.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/10/25 at 11:30 a.m., the Nurse Consultant provided an undated document titled, Skin Care & Wound Management Overview, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy .Skin care and wound management program includes, but is not limited to .Application of treatment protocols based on clinical 'best practice' standards for promoting wound healing</p> <p>On 4/10/25 at 11:30 a.m., the Nurse Consultant provided an undated document titled, Enhanced Barrier Precautions, and indicated it was the policy currently being used by the facility. The policy indicated, . Definitions .PPE [personal protective equipment] required-gowns and gloves .Policy: Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employs hand hygiene, targeted gown and glove use during high contact resident care activities that include .Wound care: any skin opening requiring a dressing .EBP are indicated for residents with any of the following .Wounds .even if the resident is not know to be infected or colonized with a MDRO [multi-drug resistant organisms]</p> <p>During an interview, on 4/10/25 at 11:38 a.m., the Nurse Consultant indicated there was no specific facility policy for dressing changes. She indicated she provided the applicable policies.</p> <p>This citation relates to Complaint IN00455170.</p> <p>3.1-18(b)(1)</p>		